

TRUCKEE TAHOE MEDICAL GROUP

Comprehensive Exam

Age _____ Birthdate: _____

Patient to complete first two pages

Best Phone #: _____

Past Medical History

No known drug allergies Allergies: _____

Past Medical/Psych Problems (diagnosis & date)

Medications (include supplements & vitamins)

Name	Dose	Times of Day	Since When
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____

Surgeries (give date)

Further Medical History (please check if you have had any of the following:)

- Stroke
- Epilepsy
- Migraines
- Depression/Anxiety
- Glaucoma
- Thyroid disease
- Diabetes
- Asthma
- Emphysema, COPD
- Sleep Apnea
- TB (Tuberculosis)
- High Blood Pressure
- Heart Disease
- High Cholesterol
- Ulcers
- Esoph Reflux
- Diverticulitis
- Pancreatitis
- Hepatitis
- Gallstones
- Hemorrhoids
- Kidney Stones

- Cancer _____
- Skin Disorders/Cancers
- Arthritis
- Gout
- Bleeding problems
- Blood clots
- Blood transfusions
- Anemia
- Alcoholism
- Drug Dependency
- Chlamydia/Gonorrhea
- Genital Herpes
- HIV

WOMEN:
 No. of Pregnancies: _____
 No. of Deliveries: _____
 Ever had abnormal Pap smear? Age _____
 Last Menstrual Period Date: _____ (or Menopause?)
 Using contraception now? _____

Habits:
 Do you Smoke or Chew Tobacco?
 Yes: How many? _____
 Since when? _____
 I quit _____ years ago.
 I smoked for _____ years.
 I have never smoked.

How often do you drink Alcohol? How much per day or week?

 Do you use other recreational drugs? If so, what type?

Immunizations:
 (Note year received)
 ___ Tetanus / Pertussis
 ___ Flu
 ___ Pneumovax
 ___ Hep B ___ Hep A
 ___ Measles, Mumps, Rubella
 ___ Chicken Pox (or had disease? _____)
 ___ Zoster (Shingles)

With whom do you live? (please give names, ages, relationship)

Type of work / Occupation? _____

What are your exercise habits? Type, Duration, Times per week

What are your eating habits? Note # of servings Fruit/Veggies

Breakfast _____ Lunch _____ Dinner _____

Have you traveled recently? Where? _____

Screening Tests: (note Year done, if applicable)

- _____ Colonoscopy
- _____ Mammogram
- _____ Pap smear / pelvic exam
- _____ PSA / prostate exam
- _____ DEXA scan (osteoporosis)
- _____ Cholesterol test

Name _____

Date _____ 1/4

Over for notes. Reviewed: _____

Family History:

Does anyone in your family have (or has anyone had) the following diseases? Please write how you are related and approximate age of diagnosis.

- Heart attacks, stents or bypass surgery at young age (men<55, women<65) _____
- Stroke _____
- Hypertension _____
- High cholesterol _____
- Diabetes _____
- Autoimmune or rheumatic diseases _____
- Cancers (esp. colon, breast, thyroid, ovarian, uterine, prostate, testicular) _____
What type? _____
- Depression, anxiety or addictions _____
- Death at a young age (cause?) _____
- Osteoporosis _____
- Other _____

Review of Systems

Place a check in the box if you have any of the following symptoms.

General

- Sleep problems
- Change in appetite
- Chills
- Fatigue
- Night sweats
- Change in weight
- Fever
- Bone pain / ache

Skin

- Mole size/color change
- Itching
- Rashes
- Bruising / bleeding

Neurologic

- Headache
- Dizziness / vertigo
- Fainting
- Numbness
- Weakness
- Tremor
- Seizure
- Memory loss
- Problems concentrating
- Off-balance

Head and Neck

- Vision changes
- Hearing difficulty / changes

- Taste changes
- Nose congestion
- Sinus problems
- Nose bleeds
- Ringing in ears
- Sore throat
- Eye pain
- Hoarseness / voice change
- Mouth dryness
- Swelling in neck
- Neck pain

Endocrine

- Excessive thirst
- Excessive urination
- Sensitive to heat/cold
- Nipple discharge
- Breast lumps
- Testicle lumps
- Hair/skin changes

Cardiovascular

- Chest pain/tightness
- Short of breath with exertion
- Ache in arms with exertion
- Short of breath at night
- Sleep with extra pillows
- Irregular heart beat

- Fast heart beat
- Swelling in legs
- Leg cramps with walking

Respiratory

- Cough
- Shortness of Breath
- Wheezing
- Bloody sputum
- Pain with breathing

Gastrointestinal

- Abdominal pain
- Indigestion / reflux
- Trouble swallowing
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Blood in stool
- Black, tar-like stools
- Change in stool
- Loss of bowel control

Genitourinary

- Blood in urine
- Pain/burning with urination
- Frequent urination
- Hard to start & stop urinating
- Loss of bladder control/incontinence

- Pain during intercourse

Men:

- Discharge from penis
- Difficulty with erections

Women:

- Vaginal discharge
- Vaginal bleeding
- Painful cramping
- Irregular periods

Musculoskeletal

- Joint Pain
- Swelling or redness
- Back pain
- Muscle aches
- Discolored fingers/toes
- Recent injuries

Psychological

- Feeling depressed
- Anxious
- Mood swings
- Thoughts of harming yourself or others
- Obsession with weight
- Binge eating

Reviewed: _____

Name _____

Date _____ 2/4